Sentinel BENEFITS

HEALTH CARE/ DEPENDENT CARE REIMBURSEMENT CLAIM FORM

EMPLOYER NAME

Commonwealth of Massachusetts

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS	SOCIAL SECURITY NUMBER

CITY	STATE	ZIP	☐ CHECK IF ADDRESS CHANGE	EMAIL ADDRESS

INSTRUCTIONS

1) Complete the above information; please print
2) Enter your expenses below
3) Complete additional information for dependent care expenses
4) Sign and date
5) Attach receipts to this form and mail or [redacted]

SENTINEL BENEFITS
601 Edgewater Drive, Suite 250
P.O. Box 4072
Wakefield, MA 01880
Tel 1.888.762.6088 Fax 781.213.7301

HEALTH CARE / DEPENDENT CARE CLAIM INFORMATION

	(H)ealth **(D)**ependent Care	Date(s) of Service	Provider of Service	Receiver of Benefit Child or Dependent	Amount Requested
1					
2					
3					
4					
5					
6					
				Total Reimbursement	

ADDITIONAL INFORMATION FOR DEPENDENT CARE EXPENSES

Dependent's Name	Relationship	Birth Date	Individual or Institution to which Dependent Care Expenses Were Paid
			NAME
			ADDRESS/CITY/STATE

SIGNATURE OF PROVIDER _____ SSN OR TAX ID _____

PROVIDE A CANCELLED CHECK OR RECEIPT

CERTIFICATION

I request payment from my reimbursement account for the expenses itemized above. I certify that I have not requested reimbursement under this plan or from any other source for these expenses. I also certify that the total dependent care expenses (if any) for which I am requesting this plan year do not exceed the lesser of my or my spouses earned income for the year. I further certify that I have met all of the requirements for eligible health care and/or dependent care expenses as described on the reverse side of this form. I understand that reimbursement expenses cannot be claimed on my personal income tax return.

SIGNATURE _____ DATE: _____

IMPORTANT INFORMATION REGARDING HEALTH CARE/DEPENDENT CARE REIMBURSEMENTS

ELIGIBLE EXPENSES UNDER A HEALTH CARE SPENDING ACCOUNT PLAN:
Eligible expenses under a HCSA are defined as those that are medically necessary, prescribed by a licensed practitioner and are not reimbursed under another program. A guideline for eligible expenses can be found in Treasury Publication 502 (Medical and Dental Expenses); it is available on the Internet at www.MyFSA.com under Publications and Forms. Important: Keep in mind that expenses such as insurance premiums may be deductible on Schedule A tax return but are not eligible for reimbursement through a HCSA. Some examples of eligible expenses are: Acupuncture, Ambulance, Artificial Limbs, Contact Lenses, Deductibles, Dental Fees, Health & Rx Co-pays, Hearing Aids, Most Over the Counter (OTC) Drugs, Orthodontic Treatment, Medically Necessary Smoking Cessation Programs/Treatments, Vaccinations, and more.

***INELIGIBLE* EXPENSES UNDER A HEALTH CARE SPENDING ACCOUNT PLAN:**
Certain health care expenses are not eligible for reimbursement from your HCSA, some of which are: Cosmetic surgery, Cosmetic procedures, Fitness programs, Non Prescription Nutritional Supplements, Hair transplants, Health club memberships, Insurance premiums, and more.

ELIGIBLE EXPENSES UNDER A DEPENDENT CARE ASSISTANCE PLAN: Eligible expenses under a Dependent Care Assistance Plan are defined as those that enable the participant and the participant's spouse to work or to look for work. They include the following:

1. Child care centers that care for six or more children and that meet the IRS's definition of a qualified day care center;
2. Caregivers for a disabled spouse or dependent who lives with the participant;
3. Babysitters;
4. Nursery schools;
5. Day Camp; and
6. Household expenses, provided that a portion of such expenses are incurred to ensure a qualifying dependent's well-being and protection.

Note: In compliance with the IRS guidelines, the service provider cannot be an individual for whom a personal tax exemption may be claimed. In addition, a child of the participant or spouse cannot be under the age of 19.

INELIGIBLE EXPENSES UNDER A DEPENDENT CARE ASSISTANCE PLAN:
1. Babysitting for social events;
2. Educational expenses; and
3. Charges for overnight camp.

SUPPORTING DOCUMENTATION: The following supporting documentation must be attached to this form:

Health Care Spending Account Plan*:* Medical and dental expenses **covered** by your health care plan must be submitted under that plan first. Attach a copy of the explanation of benefits statement to claim amounts not paid by your health care plan.

All other Health Care Spending Account expenses not submitted to your health plan: For all other expenses, attach bills or receipts that clearly state:

Name of the person receiving the service
Amount charged
Proof of Purchase
Nature of service or supplies
Name and address of provider of service
Date service was rendered
Proof of payment

Dependent Care Assistance Plan*:* Complete the requested additional information for Day Care on the front of this form. Be sure to have the Care Giver sign the front of this form, or attach a cancelled check or a receipt from the caregiver if one exists. If services are provided by a care center please provide the Tax ID#, or, if an individual please provide the Social Security Number.